PATIENT SAFETY EVENT RECOGNITION AND REPORTING

(IN THE Surgical Setting)

It is the policy of this medical center to minimize risk to patients through implementation of a uniform medical center-wide Patient Safety Program that includes reporting of adverse events.

Steps in the Patient Safety Event Reporting Process

1. **Recognize that a Patient Safety event/incident/close call has occurred.**
2. ***Report*** the event/incident/close call.
3. Recognize and report "special case" adverse events/incidents.
4. Timeliness of reporting is VERY important, and differs depending on the severity of patient impact and if it is a "special case" occurrence!

Recognize that a Patient Safety Event/Incident/Close Call has Occurred

The following are not inclusive of all Patient Safety events/incidents, but are general definitions.

A Patient Safety Event is an event, incident, or condition that could have resulted or did result in harm to a patient. A patient safety event can be, but is not necessarily, the result of a defective system or process design, a system breakdown, equipment failure, or human error. Patient Safety events also include adverse events, no-harm events, close-calls, and hazardous conditions, associated with care or services provided within the jurisdiction of a medical center, outpatient and community based clinics, or other VHA facility. Adverse events may result from acts of commission or omission (e.g., administration of wrong medication; failure to make a timely diagnosis; failure to institute appropriate therapeutic intervention, adverse reactions; or negative outcomes of treatment, etc.).

- **An Adverse Event** is a patient safety event that resulted in harm to a patient
- A No-Harm Event is a patient safety event that reaches the patient but does not cause harm
- A Close-Call (or near-miss) is a patient safety event that did not reach the patient, but must still be reported.
- A Hazardous (or unsafe) condition event is a circumstance (other than the patient's own disease process or condition) that increases the probability of an adverse event.

Patient Safety Events

- No list of patient safety events (adverse events, no-harm events, close-call events, hazardous or unsafe conditions events) can be all inclusive.
- Any event which impacts, or could potentially impact, the patient could be considered to be an "incident", and needs to be reported.
  - delays in care or treatment
  - anything that increases the patient's length of stay or level of care
  - any patient event outside of the expected (i.e. intra-operative or post-operative complication)
  - any surgery involved death
  - unplanned readmissions related to a surgical procedure
  - unanticipated returns to surgery
  - Unanticipated transfers to the ICU
- If in doubt, call Patient Safety for guidance

Patient Safety Events/Incidents – Close Calls

- **Close Calls** are events or situations that could have resulted in an accident, injury, or illness, but did not, whether by chance or through timely intervention.

CLOSE CALLS MUST ALSO BE REPORTED

Patient Safety Events

- **All Patient Safety Events require reporting and documentation** locally, in VA National Center for Patient Safety (NCPS) Information System, and Veterans Health Information Systems & Technology Architecture (VistA) – Patient Information Reporting (PIR) Package.

Clinical Disclosure

P&O 11-29, “Disclosure of Adverse Events to Patients

- A routine part of the response to a harmful or potentially harmful adverse event. Telling patients or their personal representatives about adverse events, or potentially harmful adverse events, is never easy, however, it needs to be done and with skill and tact.
- Clinical Disclosure of Adverse Events is an informal process for informing patients or their personal representatives of harmful adverse events related to the patient’s care. In a clinical disclosure, one or more members of the clinical team provides factual information to the extent it is known, expresses concern for the patient’s welfare, and reassures the patient or personal representative that steps are being taken to investigate the situation, remedy any injury, and prevent further harm. The clinical disclosure of adverse events is considered a routine part of clinical care, and needs to be made by the attending or senior practitioner, or designee.
- The conversation is documented in a regular progress note. It is NOT titled “disclosure,” nor is there documentation that a disclosure was performed. Just document that the patient and/or family was informed that “XYZ” occurred, what is being done for the patient, that you apologized, and that the patient/family was asked if they had any questions and had those questions answered.

Sentinel Events

- **Sentinel Events** are a type of adverse event. Sentinel events, as defined by The Joint Commission, are patient safety events (not primarily related to the natural course of the patient's illness or underlying condition) that reach a patient and result in any of the following: death, permanent harm, or severe temporary harm.*
- An event is also considered Sentinel if it is one of the following:
    - Wrong site surgery
    - Surgery on the wrong patient
    - Wrong procedure
    - Unintended retention of a foreign object in a patient after an invasive procedure, including surgery
    - Any fire, flame, or unanticipated smoke, heat, or flashes

*Severe Temporary Harm is critical, potentially life-threatening harm lasting for a limited time with no permanent residual, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition.

- A **Sentinel Event** is to be reported **IMMEDIATELY** upon discovery to your supervisor/service chief/patient safety/pentad. The telephone is generally the best way to accomplish this.

Special Case Patient Safety Events/Incidents (Serious Incidents)

- **Sentinel Events** (patient safety events (not primarily related to the natural course of the patient's illness or underlying condition) that reach a patient and result in any of the following: death, permanent harm, or severe temporary harm.)
- **Missing Patients** (if not found on VA Grounds)
- **Suspected abuse/assaults/rapes**

Pick up the phone and report immediately!!

Special Case Patient Safety Events/Incidents (Serious Incidents)

Serious Events that Must be Reported to Outside Agencies within

2 Hours

- Sexual Assaults/Aggravated Assaults/Child Abuse
- Terrorist Event/Credible Threat
- Major Theft/Loss or Loss of Sensitive Data
- Activation of Emergency Plans
- VA Police Involved Shootings
- On-Property Deaths from : Homicide, Suicide, Accidents, or Suspicious Deaths
- Major disruptions to Operations
- Arrest of VA Employee

Pick up the phone and report immediately!!

Culture of Safety

- A culture of safety will be developed by improved reporting of incidents, close calls, and educating staff in patient safety.

Reporting Patient Safety Events

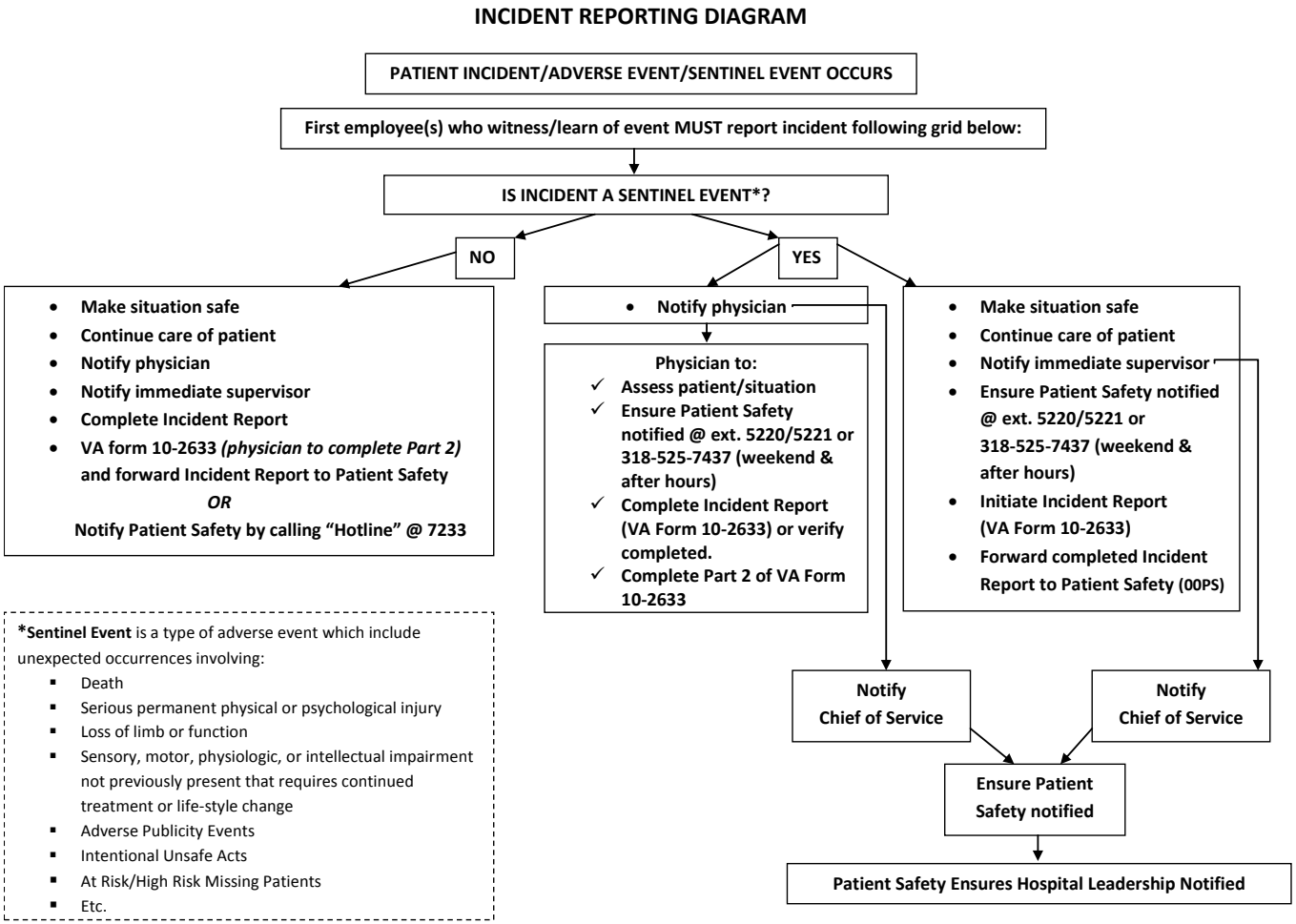
- The first employee or employees who witnesses or learns of an patient safety event will report it by completing VA Form 10-2633, “Report of Special Incident Involving A Beneficiary,” or by calling the Patient Safety at 5221/5220, or by calling the “Hotline” number at extension 7233 and reporting pertinent information.

Reporting Patient Safety Events

- If multiple employees witness or learn of a patient safety event, the employees must ensure that the adverse event has been reported using one of the reporting options.

Incident Reporting Algorithm

ATTACHMENT C



What does "Stop the Line" mean?

The idea began in the auto manufacturing industry; management gave everyone working at the plant the authority to stop the production line if they saw a mistake. Quality improved dramatically.

"Stop the Line"

- How does "Stop the Line" apply to the care we provide Veterans?

Stopping the line is about creating a **Culture of Safety** and a **Just Culture**, empowering our fellow staff members, whether they are clinical staff in the ICU or engineering staff at the boiler plant, to feel safe and protected when voicing concerns about safety.

- How do we want our employees to speak up when they have a concern?

By using a simple tool called the "3 Ws"

- **What I see**
- **What I'm concerned about**
- **What I want**

It's Okay to "Stop the Line!"

Questions?

- If you have any questions regarding Patient Safety, refer to the **Patient Safety Program Policy (00-05)** on the intranet, or contact the **Patient Safety Manager (PSM) at extension 5221 or 5220**. After hours, the PSM can be contacted through the NOD (nursing supervisor)